

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-015591

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 120

Primary Registration District No. 4194

Registrar's No. 36

FILED APR 30 1963

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Gentry</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Harrison</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Albany</u> | | c. CITY OR TOWN <u>White Oak Twp.</u> | |
| Length of stay in 1b <u>6 Mo.</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>no</u> | | d. STREET ADDRESS (If outside, give location) <u>8 Mile SW Bethany</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Green</u> Last <u>Green</u> | | 4. DATE OF DEATH Month <u>4</u> Day <u>24</u> Year <u>1963</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-18-68</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11a. FATHER'S NAME <u>Marcus Green</u> | | 11b. MOTHER'S MAIDEN NAME <u>Frances Johnson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>May Porter, Morristown, N. J.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>senility</u> DUE TO (b) <u>senility</u> DUE TO (c) <u>senility</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour <u>6 a.m.</u> Month, Day, Year <u>April 16</u> | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from <u>April 16</u> to <u>April 23</u> and last saw her alive on <u>April 22-63</u> Death occurred at <u>6 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) <u>C. J. Pray</u> 22b. ADDRESS <u>D. O. Albany, Mo.</u> 22c. DATE SIGNED <u>4-27-63</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>4-28-1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>new Hampton, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>M. B. Haas</u> | 25. DATE RECD. BY LOCAL REG. <u>4-27-63</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. L. W. Bare</u> | |

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

Recd
4-27-63

Ch. 10.11

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer.

Signed M. J. Loe

Licensed Embalmer No. 3899

P. O. Address Bethany, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.